

<b>Case Number:</b>	CM14-0025697		
<b>Date Assigned:</b>	06/04/2014	<b>Date of Injury:</b>	12/24/2010
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	02/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/01/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 54 year old female whose date of injury is 12/24/2010. On this date the injured worker was reportedly physically and sexually assaulted. A medical legal report dated 05/20/14 indicates that the injured worker has been diagnosed with cervical disc disease, cervical radiculopathy, bilateral shoulder sprain/strain, lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, status post bilateral surgery and pacemaker.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **BILATERAL L3-4 AND L4-5 TRANSFORAMINAL EPIDURAL STEROID INJECTIONS.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on Epidural Steroid Injections Page(s): 46.

**Decision rationale:** The MTUS Chronic Pain Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. There is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy, and there are no imaging studies/electrodiagnostic

results submitted for review. There is no comprehensive assessment of treatment completed to date or the injured worker's response thereto submitted for review to establish that she has been unresponsive to conservative treatment as required by the MTUS Chronic Pain Guidelines. As such, the request is not medically necessary and appropriate.

**INTERFERENTIAL UNIT FOR HOME USE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 118-120.

**Decision rationale:** Based on the clinical information provided, the request for interferential unit for home use is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no indication that the injured worker has undergone a trial of Transcutaneous Electrical Nerve Stimulation (TENS) or interferential units as required by the MTUS Chronic Pain Guidelines. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals are provided. As such the request is not medically necessary and appropriate.

**PAIN MANAGEMENT REFERRAL:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7) page 127.

**Decision rationale:** Based on the clinical information provided, the request for pain management referral is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the injured worker's response thereto submitted for review. There is no current, detailed physical examination submitted for review and no imaging studies, radiographic reports or electrodiagnostic results were provided. It is unclear how the referral will aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work as required by the ACOEM Guidelines.